DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11049 (Rev. 06/03)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Drug Attachment (PA/DGA) Completion Instructions (HCF 11049A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Date of Birth — Recipient

3. Recipient Medicaid Identification Number

SECTION II — TYPE OF REQUEST

4. Indicate the Start Date Requested / Date Prescription Filled

5. Indicate if this drug has been previously requested.

❑ This is an initial PA request for this drug, for this recipient, by this provider.

❑ This is a request to renew or extend previously prior authorized therapy using this drug.

First PA Number_____

❑ This is a request to change or add a new National Drug Code (NDC) number to a current valid PA.

First PA Number_____ NDC Number to add _____

SECTION III — PRESCRIPTION INFORMATION

6. Drug Name

7. Strength

8. Quantity Ordered

9. Date Order Issued

10. Directions for Use

11. Daily Dose

12. Refills

13. Name — Prescriber

14. Drug Enforcement Agency Number

15. "Brand Medically Necessary" is handwritten by the prescriber on the prescription order. ❑ Yes ❑ No

Continued

SECTION IV — CLINICAL INFORMATION

16. List the recipient's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code for pharmaceutical care recipients. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

17. Source for Clinical Information (check one)

- ❑ This information was primarily obtained from the prescriber or prescription order.
- ❑ This information was primarily obtained from the recipient.
- ❑ This information was primarily obtained from some other source (specify). _____

_____

_____

18. Use (check one)

- ❑ Compendial standards, such as the United States Pharmacopeia Drug Information (USP DI) or drug package insert, lists the intended use identified above as an expected indication.
- ❑ Compendial standards, such as the USP DI, lists the intended use identified above as a [bracketed] accepted application.
- ❑ Compendial standards, such as the USP DI or drug package insert, lists the intended use identified above as an expected use.
- ❑ The intended use above is not listed in compendial standards. Peer reviewed clinical literature is attached or referenced. (Reference — include publication name, date, and page number.

19. Dose (check one)

- ❑ The daily dose and duration are within compendial standards general prescribing or dosing limits for the indicated use.
- ❑ The daily dose and duration are **not** within compendial standards general prescribing or dosing limits for the intended use. Attach or reference peer-reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference — include publication name, date, and page number.)

20. **SIGNATURE** — Pharmacist or Dispensing Physician	21. Date Signed

22. Please notify me of approval or denial by:

- ❑ Fax (include Fax number) _____
- ❑ Telephone (include telephone number) _____
- ❑ No special notice needed.

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